



*In loving memory of Cathy Teschke,
Director of SJO Community Clinics April 1999 to December 2012*

St. Joseph Hospital Orange

**Fiscal Year 2013 COMMUNITY BENEFIT REPORT
PROGRESS ON FY12 - FY14 CB PLAN/
IMPLEMENTATION STRATEGY REPORT**

St. Joseph Health 
St. Joseph Hospital

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EXECUTIVE SUMMARY

Our Mission

To extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.

Our Vision

We bring people together to provide compassionate care, promote health improvement and create healthy communities.

Our Values

The four core values of St. Joseph Health -- Service, Excellence, Dignity and Justice -- are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.

Who We Are and What We Do

St. Joseph Hospital of Orange (SJO) is a values-based Catholic healthcare provider with a tradition of and commitment to excellence, based on the vision of the Sisters of St. Joseph of Orange. The hospital's strong belief in the intrinsic dignity of each person commits it to be a just employer to its 3,800 employees; to provide healthcare for the whole person, body, mind and spirit; and to collaborate with the 1000-member medical staff and other healthcare providers to increase access to quality health care. As a nonprofit community hospital, SJO is committed to offering care to those in need without regard to their financial status or level of insurance. This is especially important since Orange County does not have a county hospital to provide services to low-income families. Our hospital provides comprehensive care to some of the poorest communities in Southern California - including some in Santa Ana – a city determined by the Nelson A. Rockefeller Institute of Government in their most recent Update on Urban Hardship as being the most difficult urban area in the United States in which to live .

SJO provides a comprehensive range of services, centers and programs: Anesthesia Services, Bariatric Surgery Program, In-patient Behavioral Health Services, Blood Donor Center, The Center for Breast Imaging and Diagnosis, The Center for Cancer Prevention and Treatment, Clinical Education, Colorectal Program, Emergency, Endoscopy, Heart and Vascular Center, Home Health, Kidney Dialysis Center, Kidney Transplant Center, Maternity, Minimally Invasive Urology & Stone Center, Nasal & Sinus Center, Neurosurgical Services, Nursing Excellence, Ophthalmology, Orthopedics, Pathology Services, Radiology & Imaging Services, Rehabilitation Services, Research, Respiratory Services, Robotics and Minimally Invasive Treatment, Sleep Disorders Center, Stroke Program, Surgical Services, Technology, Women's Services, and Wound Care Center.

In FY 13, SJO Community Clinics provided medical, dental and vision services to 7,758 individual patients and 17,322 patient encounters. The Joint Clinic Health Education Program, El Club de Salud provided a total of 1,686 health education encounters. Eight hundred forty six (846) new patients enrolled in El Club de Salud Program. This was the result of multiple efforts by Health Education and clinic staff in identifying patients that would benefit from El Club chronic disease management and health education activities. Seventeen percent (17.4%) of SJO students from the Childhood Obesity Prevention and Intervention Program, Healthy 4 Life, decreased their weight status to a healthier category (56 of 321). The percentage of dental treatment completion for low-income children by year end was 44%. The Postpartum Depression Program (PPD), the only screening and treatment hospital-based program in Orange County screened 618 women for PPD. Of those who began treatment, 100% recovered from postpartum depression.

In FY 13, SJO provided **\$45,475,633 for community benefit programs/activities**. This includes services for the poor, vulnerable and at risk populations as well as for the broader community. Unpaid costs to **Medicare totaled \$29,599,866**.

Overview of Community Needs and Assets Assessment

In collaboration with community partners, St. Joseph Hospital Orange participates in the Orange County Health Needs Assessment (OCHNA). OCHNA is a community-based, not-for-profit

collaborative that was created and designed to meet the requirements of SB697 for all not-for-profit hospitals in Orange County; the collaborative is jointly funded by the Health Care Agency of Orange County, the Children and Families Commission, CalOptima, and the nine Orange County not-for-profit HASC member hospitals.

Due to the economic downturn, county hospitals and governmental partners were unable to provide sufficient funding to conduct the random digit dial telephone survey of 5,000 households for the Orange County 2010 health needs assessment. An alternative needs assessment plan was developed that incorporated a mix mode approach to data collection that included a trend analysis of four previous OCHNA health needs surveys (1998, 2001, 2004, and 2007), as well as additional primary data from the Census Bureau's American Community Survey and the California Health Information Survey. Population estimates for OCHNA 1998 and 2001 were updated with the latest estimates from the State of California Department of Finance, so the estimates provided for the county will differ from county estimates provided in previous reports released by OCHNA. In addition, OCHNA incorporated

objective/secondary data sources, demographics/census data, and a key informant survey that OCHNA administered online, to be used as the source of qualitative data.

Objective/secondary data came from numerous sources (all cited within the report), including Dept. of Finance, 2009 Census estimates by Nielsen Claritas, Orange County Health Care Agency, and Healthy People 2010 (used as benchmarks). Qualitative data was obtained through a key informant survey of community based organizations, foundations, health advocates, community clinics, local political/policy leaders, public health organizations, and other hospitals.

In addition, OCHNA conducted a web-based survey for key informants (local health care leaders) in the community. Key informants provided their opinions about the health needs of the county, barriers faced by patients accessing care, challenges in the county health care system, as well as the forms and quality of collaborative relationships among their organizations, service area hospitals and other groups.

SJO's Community Benefit Service Area (CBSA) strictly focuses on the most vulnerable members of our community and it is comprised of key communities and zip codes where health disparities and socioeconomic indicators demonstrate the highest need and significant barriers to health care access.

These communities and zip codes include: Santa Ana (92701, 92703, 92704, 92706, 92707); Anaheim (92801, 92802, 92804, 92805, 92806, 92807); Garden Grove (92840, 92841, 92843, 92844); Orange (92865, 92866, 92867, 92868, 92869); Tustin (92780, 92782); Westminster (92683) Costa Mesa (92626, 92627); Huntington Beach (92647); Stanton (90680)

Secondary CBSA include: Fullerton (92831, 92832, 92833, 92835); Placentia (92870); La Habra (90631); Brea (92821); Buena Park (90620, 90621).

Community Benefit is characterized as programs or activities that promote health and healing in response to identified community needs. In order to accurately define community need, we used two tools provided by St. Joseph Health. The first tool, The Community Need Index (CNI) was developed by Catholic Healthcare West (CHW) and Solucient (an information products company). CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers). Barriers include: Income; elder poverty, child poverty and single parent poverty; Culture, non-Caucasian limited English; Education, % population without HS diploma; Insurance, unemployed and uninsured; and Housing, renting percentage.

CNI demonstrates need at the zip-code level where each zip is assigned a score from 1 (low need) to 5 (high need) for each barrier. For barriers with more than one measure, the average of the measures is used as the barrier score. Once each zip code is assigned a score from 1 to 5 for each of the five barriers, the average score is calculated to yield the CNI.

Color-Coded Maps

Red- Highest Need (CNI scores: 4.2-5)

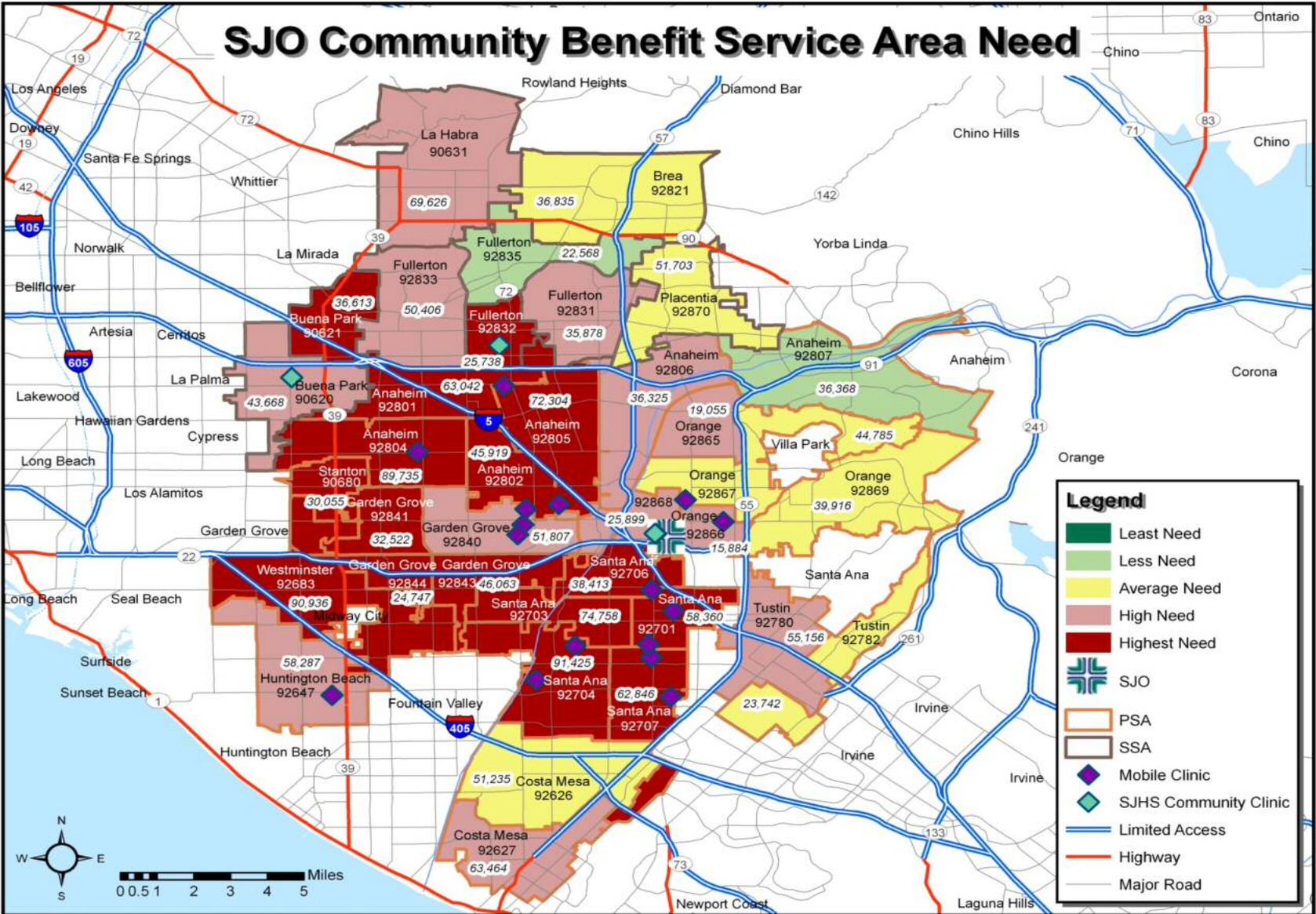
Pink- High Need (CNI scores: 3.4-4.1)

Yellow- Average Need (CNI scores: 2.6-3.3)

Light Green- Less Need (CNI Scores: 1.8-2.5)

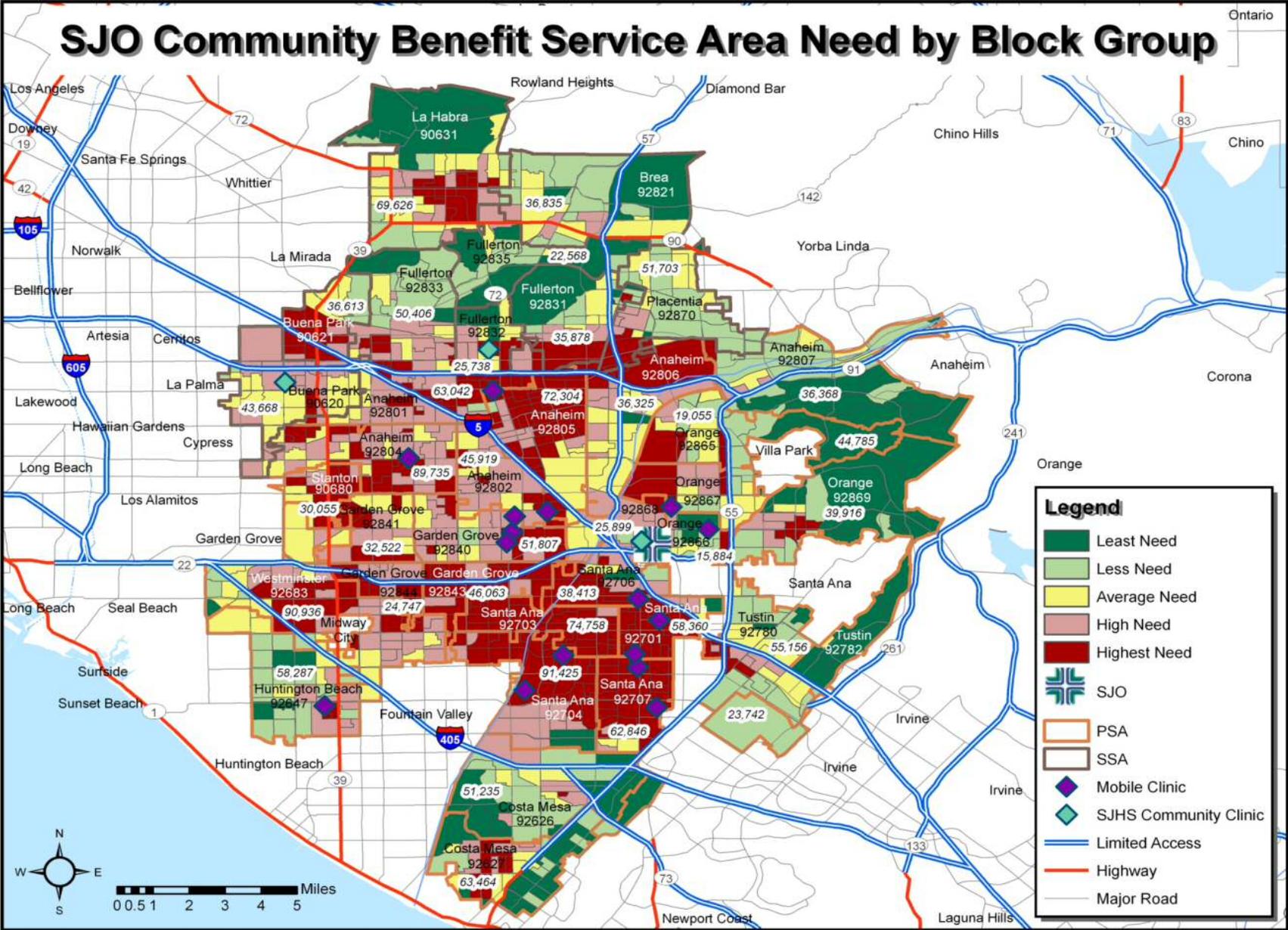
Dark Green- Least Need (CNI Scores: 1-1.7)

The second tool, Intercity Hardship Index (IHI) was developed by the Urban & Metropolitan Studies Program at the Nelson A. Rockefeller Institute of Government. IHI aggregates six socioeconomic indicators that contribute to health disparity (at the block group level). Indicators include: Income level, per capita Income; Crowded Housing, % of households with 7+ people; Unemployment, % of those 16 and over without employment; Education, % of those 25 and over without a HS diploma; Poverty, % of people living below FPL; and Dependency, % of the population under 18 years and over 64 years.



Source: Community Need Index, Catholic Healthcare West, 2011

Prepared by the St. Joseph Health System Community Health Department



Source: Intercity Hardship Index, The Nelson A. Rockefeller Institute of Government, 2007

Prepared by the St. Joseph Health System Community Health Department

Community Plan Priorities/Implementation Strategies

The following information provides a brief summary of accomplishments associated with each of the Community Benefit Initiatives for FY13:

- **Initiative #1: Access to Primary Care**
 - The goal of increasing access to the underserved population was achieved through La Amistad Medical services and Puente Medical & Vision services. The number of unduplicated patients served by Medical and Vision services totaled 7,758. A total of 419 patients received low-cost prescription frames (cost per frame is \$6 - \$16). Puente Medical and Vision mobile services engaged 5 new community partners to provide access to care to the underserved in their communities. In addition, the number of low-income children enrolled in appropriate health insurance programs totaled 1,899.

- **Initiative #2: Access to Dental Care**
 - The percentage of children and adults with caries was 36% by year end compared to 43% at baseline. The percentage of dental treatment completion for children by year end was 44% compared to 43% at baseline. Puente Dental mobile services engaged 7 new collaborative partners to provide access to care to the underserved in their communities.

- **Initiative #3: Wellness, Prevention and Intervention**
 - The percentage of persons defined as at risk for negative health outcomes was 41% compared to 45% at baseline. The 4% decrease of at risk persons is due to multiple efforts to identify persons at risk. Seventeen percent (17.4%) of SJO students decreased their weight status to a healthier category (56 of 321).

- **Initiative #4: Postpartum Depression Program**
 - 100% of mothers who entered treatment for Postpartum Depression recovered compared to 85% at baseline. On average, 5 sessions were provided to mothers who completed treatment. PPD implemented a low cost fee program for individual and group sessions in an effort to reduce the financial burden to clients. 100% of mothers, who required medication during the program, received appropriate medication, used their medication, and recovered from postpartum depression. PPD provided 618 individual and/or group sessions to mothers with postpartum depression.

INTRODUCTION

Who We Are and Why We Exist

For over 80 years, St. Joseph Hospital of Orange (SJO) has been dedicated to continually improving the health and quality of life of the people in the communities it serves. Located in the heart of Orange County, SJO is a 525-bed not-for-profit, acute care facility with approximately 3,800 employees and 1,000 physicians on Staff. SJO has the second busiest Emergency Room in the state of California and the busiest in Orange County (101,945 visits). It is the first in Orange County and second in the State of California for surgical volume (28,027 procedures). SJO is second in Orange County for the number of deliveries (5,149 live births), and first in Orange County for cardiac catheterizations (3,221).

SJO provides a comprehensive range of services, centers and programs: Anesthesia Services, Bariatric Surgery Program, In-patient Behavioral Health Services, Blood Donor Center, The Center for Breast Imaging and Diagnosis, The Center for Cancer Prevention and Treatment, Clinical Education, Colorectal Program, Emergency, Endoscopy, Heart and Vascular Center, Home Health, Kidney Dialysis Center, Kidney Transplant Center, Maternity, Minimally Invasive Urology & Stone Center, Nasal & Sinus Center, Neurosurgical Services, Nursing Excellence, Ophthalmology, Orthopedics, Pathology Services, Radiology & Imaging Services, Rehabilitation Services, Research, Respiratory Services, Robotics and Minimally Invasive Treatment, Sleep Disorders Center, Stroke Program, Surgical Services, Technology, Women's Services, and Wound Care Center.

SJO has a solid reputation for top-notch care. This outstanding reputation is substantiated by these and other recent honors:

- The California Hospital Assessment and Reporting Taskforce (CHART) presented St. Joseph Hospital with a third consecutive "Certificate of Excellence" based on quality data through August 2010. Only three Orange County hospitals earned the accolade.
- In the October 2010 issue of Consumer Reports, thoracic and cardiovascular surgeons based at St. Joseph Hospital were listed as one of the nation's top 50 groups, one of the three top groups in California, and were the only group in Orange County named. This was the first ever rating of doctors in Consumer Reports.
- U.S. News & World Report has recognized St. Joseph Hospital as one of the top hospitals in Los Angeles/ Orange County for 2011, providing clinical excellence in seven specialties.

- Achieved Magnet designation for nursing excellence, the highest recognition in the nursing profession.
- Selected by the National Cancer Institute (NCI) to participate in its Community Cancer Centers Pilot Program (NCCCP). St. Joseph Hospital is the only hospital on the West Coast named to participate in this prestigious program.
- St. Joseph Hospital was named among the top 60 hospitals in the nation for its outstanding orthopedic program by Becker's Hospital Review.
- St. Joseph Hospital has been named one of Orange County's most trusted brands in 2010 and 2011, based on an independent survey of consumer attitudes and opinions conducted by The Values Institute at Santa Ana-based DGWB Advertising and Communications and OC METRO.

In FY 13, our community benefit programs provided direct medical services, offered preventive care and education, and participated in various collaborative partnerships to deliver a greater impact on the communities we serve. One example of such success is our Puente a la Salud Vision Mobile Clinic. The Vision Mobile provides comprehensive vision and eye health diagnostics, education and treatment services for eye disease and injury to low-income individuals and families throughout Orange County. Puente partners with trusted community sites throughout Orange County and arranges to park the mobile clinic at their locations so low-income individuals in the community have easy access to appointments. Patients receive treatment to reduce eye disease and incidence of blindness and receive corrective lenses for refractive problems. Puente's vision clinic is well-equipped and provided comprehensive vision care, including glaucoma testing, retinal imaging, refraction and provision of corrective eyewear and optical supplies.

Back in 2013, a 55 year old female patient with diabetes and hypertension was referred to Puente Vision Mobile Clinic for a routine diabetic retinal screening exam from our La Amistad Family Health Center. According to Dr. Rofsky, the Optometrist, her exam turned out to be not so "routine." The patient commented that, for the past 7 months, she had been experiencing transient headaches and corresponding drooping of her right eyelid. This would occur a couple times per week, lasting only minutes, but overall her symptoms were worsening. She did not notice any changes in pupil size in either eye. The patient's exam was essentially normal. No sign of a droopy lid, pupil abnormality or muscle abnormality was observed. She had good corrected visual acuity. Her optic nerves were normal, and she had no detectable diabetic retinopathy. Although the patient's exam was normal, her symptoms were concerning. Dr. Rofsky discussed her symptoms with her care provider at the La Amistad, and recommended she undergo brain imaging with MRI. An MRI revealed a pituitary tumor. The patient underwent successful neurosurgery for resection of the tumor. When the patient returned for her follow-up

exam, she reported her symptoms had resolved, she felt much better, and she was grateful for the care she had received.

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Community Benefit Governance Structure

The Community Benefit Committee meets six times a year. Two of the hospital's senior Executive Management Team (EMT) members serve on the Community Benefit Committee: the Chief Executive Officer/ President and the Vice President of Mission Integration. The Community Benefit Committee consists of at least eight (8) members. The Committee includes at least three (3) members of the Board of Trustees. A majority of the Committee consists of members from the community who have knowledge and experience with populations who have Disproportionate Unmet Health Needs. The Trustees and EMT receive regular updates on Community Benefit Programs' progress and outcomes status. Per the Community Benefit Committee Charter, the Committee's involvement with Community Benefit programs included overseeing and providing general direction to the Hospital's Community Benefit activities including:

- a. Budgeting decisions- Review, approve, and recommend the Care for the Poor budget and all community benefit expenditures annually.
- b. Program content- Review, approve, and recommend new community benefit program content.
- c. Program design- Review, approve, and recommend overall program design that will best meet the need of the community(ies) served.
- d. Geographic/population targeting- Insure that community benefit programs target communities with disproportionate unmet health needs in the service area of the Corporation.
- e. Program continuation/termination- Review and recommend programs for continuation/ discontinuation annually.
- f. Fund Development support- Identify funding sources and partnerships for community benefit programs. Provide letters of support or introduction as appropriate.
- g. Community wide Engagement- Assure effective communication and engagement of diverse stakeholders in community benefit planning and implementation.

Planning for the Uninsured and Underinsured Patient Financial Assistance Program

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why St. Joseph Health, St. Joseph Hospital Orange has a **Patient Financial Assistance Program (FAP)** that provides free or discounted services to eligible patients. In FY 13, St. Joseph Health, St. Joseph Hospital Orange, provided \$8,698,922 in charity care and 22,139 encounters.

One way St. Joseph Health, St. Joseph Hospital Orange, informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible.

COMMUNITY

Defining the Community

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These communities and zip codes include:

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COMMUNITY NEEDS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

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The Orange County Health Needs Assessment (OCHNA) was a community-based, not-for-profit collaborative that was created and designed to meet the requirements of SB697 for all not-for-profit hospitals in Orange County. The collaborative was jointly funded by the Health Care Agency of Orange County, the Children and Families Commission, CalOptima, and the nine Orange County not-for-profit HASC member hospitals. As of June 20, 2012, the OCHNA Collaborative is no longer in existence.

Due to the economic downturn, county hospitals and governmental partners were unable to provide sufficient funding to conduct the random digit dial telephone survey of 5,000 households for the Orange County 2010 health needs assessment. An alternative needs assessment plan was developed that incorporated a mix mode approach to data collection that included a trend analysis of four previous OCHNA health needs surveys (1998, 2001, 2004, and 2007), as well as additional primary data from the Census Bureau's American Community Survey and the California Health Information Survey. Population estimates for OCHNA 1998 and 2001 were updated with the latest estimates from the State of California Department of Finance, so the estimates provided for the county will differ from county estimates provided in previous reports released by OCHNA. In addition, OCHNA incorporated objective/secondary data sources, demographics/census data, and a key informant survey that OCHNA administered online, to be used as the source of qualitative data.

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St. Joseph Hospital Service Area Population, 2010						
	St. Joseph Hospital Service Area		Primary Community Benefits Service Area		Secondary Community Benefits Service Area	
	Population Estimate	% of OC Population	Population Estimate	% of OC Population	Population Estimate	% of OC Population
Population Size	2,309,034	74.7%	1,345,048	43.5%	373,035	12.1%
Household Size	703,502	70.3%	371,870	37.2%	120,288	12.0%
Age Distribution of Service Area						
Age Groups	Population Estimate	% of Service Area	Population Estimate	% of Service Area	Population Estimate	% of Service Area
0-4 Years	171,033	7.4%	111,739	8.3%	26,457	7.1%
5-9 Years	163,662	7.1%	103,507	7.7%	25,474	6.8%
10-14 Years	163,756	7.1%	102,463	7.6%	25,671	6.9%
15-17 Years	100,838	4.4%	59,265	4.4%	15,986	4.3%
18-24 Years	236,727	10.3%	137,295	10.2%	38,126	10.2%
25-44 Years	670,375	29.0%	408,382	30.3%	104,662	28.0%
45-64 Years	561,438	24.3%	295,088	21.9%	91,673	24.6%
65+ Years	241,205	10.4%	127,309	9.6%	44,986	12.1%
Race/Ethnicity Distribution						
Race/Ethnicity	Population Estimate	% of Service Area	Population Estimate	% of Service Area	Population Estimate	% of Service Area
White	853,311	37.0%	356,740	26.5%	144,000	38.6%
Hispanic/Latino	903,399	39.1%	706,987	52.6%	143,569	38.5%
Vietnamese	157,523	6.8%	122,069	9.1%	5,433	1.5%
Other Asian or Pacific	287,573	12.5%	128,870	9.6%	60,173	16.1%
Black or African	37,072	1.6%	20,313	1.5%	9,021	2.4%
Other	70,156	3.0%	10,069	0.7%	10,839	2.9%

Source: 2010 US Census Estimates by Nielsen Claritas

- **43.5%** (1,345,048) of the Orange County population resided in the primary community benefits service area.
- **Over half (52.6%)** of the population in the primary community benefits service area were Hispanic/Latino, compared to **39.1%** in the hospital service area.
- Close to **one in five (18.7%)** in the primary community benefits service area was with either Vietnamese (**9.1%**) or Other Asian or Pacific Islander (**9.6%**).

- Close to **one in three (30.3%)** adults in the primary community benefits service area was in the age group 25 to 45 years of age.
- Over **one in four (28%)** residents in the primary community benefits service area was under 18 years of age.
- **12.1%** (373,035) of the Orange County population resided in the secondary community benefits service area.
- There is an equal population distribution amongst whites (**38.6%**) and Hispanic/Latinos (**38.5%**) in the secondary community benefits service area.
- Other Asian or Pacific Islanders account for **16.1%** of the population in the secondary community benefits service area, compared to only **1.5%** of Vietnamese.
- Over **one in four (28%)** of adults in the secondary community benefits service area was between the ages of 25-44. **One in four (25%)** of residents in the secondary community benefits service area was under 18 years of age.

Top 5 Cities where Latinos Reside in Orange County, 2009		
City of Residence	Percent of O.C. Hispanics	Population Estimate
Santa Ana	26.2%	270,736
Anaheim	17.5%	180,666
Garden Grove	6.8%	70,687
Orange	5.3%	54,320
Fullerton	4.4%	45,393

Source: U.S. Census Bureau, 2009 American Community Survey

Table 4: Language Spoken at Home (5+ Years): St. Joseph Hospital Service Area, 2010		
Language	St. Joseph Hospital Service Area	Primary Community Benefits Area
English Only	49.7% 1,063,259	39.3% 484,120
Asian or PI Language	14.6% 313,075	14.3% 175,786
Indo-European Language	3.6% 76,795	2.5% 30,178
Spanish	31.2% 666,100	43.4% 534,418
Other Language	0.9% 18,772	0.7% 8,807
Population 5+ Years	2,138,001	1,233,309

Source: 2010 US Census Estimates by Nielsen Claritas

- 1 in 8 households (13% or 93,518) in the SJH service area had an annual income of less than \$25,000.
- The median household income in both community benefits service areas is lower than the Hospital service area's median of **\$71,563**.
- The cities of Anaheim, Garden Grove, Santa Ana and Stanton all had median household incomes below **\$60,000**.
- There were no cities with a median household income above \$100,000 in the community benefits service area, the city with the highest median household income was Placentia, in the secondary community benefits service area, with a median household income of **\$81,463**.
- From **1998** through **2007** Orange County the number of adults and children **without** health coverage decreased significantly; for adults it dropped from a high of under **15%** to a low of **9%**; for children it dropped from about **11%** to less than **4%**.
- Overall the uncovered rate in Orange County has **more than doubled from 2007 to 2009** for both adults (increasing from **9%** to **20%**) and children (increasing from under **4%** to just over **10%**). For adults, the 2009 rate is higher than the 1998 rate estimated by the OCHNA survey.
- Ethnic/minority populations throughout Orange County have experienced the largest losses of health care coverage, with almost **1 in 3 Hispanic/Latino (32%)** individuals having **no health care coverage**.
- Latino children are over **4 times (16%)** more likely than white children (**3%**) to be without health care coverage, and just over **43%** of Latino adults and **15%** of all Asians are **without** coverage health care coverage.
- Uninsured rates are even worse in cities that have higher proportion of low income, and minority populations, with double digit unemployment rates.
- **Santa Ana:** **47%** of Adults (18-64) and **20%** of children (0-17) were **without** health coverage; rate of unemployment rose from **6%** in 2007 to **14%** as of October 2010.
- **Garden Grove:** **35%** of Adults (18-64) and **13%** of children (0-17) were uncovered; rate of unemployment rose from **5%** in 2007 to **11%** as of October 2010.
- **Orange:** **28%** of Adults (18-64) and **12%** of children (0-17) were uncovered; rate of unemployment rose from **4%** in 2007 to **8%** as of October 2010.
- **Anaheim:** **31%** of Adults (18-64) and **12%** of children (0-17) were uncovered; rate of unemployment rose from **5%** in 2007 to **12%** as of October 2010.

With the dramatic loss of health coverage among Orange County residents, it follows that there has been an accompanying loss of dental coverage in the population; almost

13% of Orange County children and 24.0% of Orange County adults lacked health coverage in 2009. It is probable that an even greater percentage of children and adults lacked dental coverage for that year. **Denti-Cal Policy Changes and Impact-** Most preventative dental services to adults ages 21 years and older were eliminated as of July 1, 2009 due to the state budget crisis, except for limited dental services for the “relief of pain and infection,” such as a tooth removal.

- **Almost 25% (87,142)** of children 6 to 17 years of age spent **3 or more hours** watching TV or playing video games, and **10.8% (38,149)** spent **3 or more hours** using the computer or surfing the Internet.
- **California Physical Fitness (PFT)** – Rates on 6 standards: Aerobic Capacity, Body Composition, Flexibility, Abdominal, Trunk and Upper Body Strength
Results for SJH service area:
 - In the **2008-09** school year only **34% (9,609)** students) of 5th graders, **42% (12,685)** students) of 7th graders, and **43% (14,106)** students) of 9th graders met all of the six fitness standards.
 - In the **2007-08** school year, **32% (9,347)** students) of 5th graders, **41% (12,250)** students) of 7th graders, and **42% (13,341)** students) of 9th graders met all of the six fitness standards.
 - In the **2000-01** school year, **26% (7,946)** students) of 5th graders, **31% (9,052)** students) of 7th graders, and **31% (7,545)** students) of 9th graders met all of the six fitness standards.
- The St. Joseph service area falls short of the Healthy People 2020 Objective of **14.6%** of children and adolescents who are overweight; **19.9%** (72,008) were overweight in 2007, **5.3** percentage points more than the HP 2020 Objective.
- **6.9%** (111,256) of adults reported that they were diagnosed with emotional, mental, and behavioral health disorders by a doctor or other health care provider; **25.8%** (27,870) of those have never received treatment for their condition.
- In the SJH service area, **28.3%** (53,927) of adults who were told by a doctor that they had a disorder or that they should seek professional mental health care did not receive treatment or counseling.
- **30.2%** (13,644) of adults who needed treatment could not receive it either because they could not afford treatment and/or they had no coverage for mental health treatment.

As mentioned previously, objective/secondary data from The Orange County Health Care Agency Research and Planning - OC Geographic Health Profile 2001, provided key health indicators to convey geographic distribution and to identify areas of need.

This data source provides a different scope and a broader picture of the impact of identified needs on the current infrastructure. The following are summary findings relevant to Central OC.

- Over half a million people in the county do not have health insurance (535,173 or 17.7% of the population). One in ten children does not have insurance (10.4%).
- The cities with the highest percentage of uninsured children included Santa Ana (20%) and Fullerton (17.5%). Other cities with high rates of children who do not have health insurance include Garden Grove (13%), Anaheim (11.8%), and Orange (11.6%).
- 15.2% of all OC children were below the poverty level.
- OC's unemployment rate (not seasonally adjusted) was 9.6% in September 2010.
- Fourteen zip codes from Westminster, Santa Ana, Anaheim, Garden Grove, Costa Mesa and Fountain Valley accounted for more than 50% of the MSI population.
- Fifteen zip codes from Santa Ana, Anaheim, Garden Grove, La Habra, Tustin, Costa Mesa, and Westminster accounted for over half (57%) of the county Medi-Cal eligible population.
- SJH had the second highest percentage of hospital discharges at 8.3% or 3-year average 26,863.
- SJH was among the five hospitals with the highest percentage of hospital discharges for Latinos (10%).
- SJH had the second most birth-related discharges (3-year average 10,532).
- Latinos had the highest natality rate (crude birth rate) at 20.3 per 1,000 population. The second highest group was Asian/Pacific Islander with a rate of 13.1 per 1,000. Countywide average is 13.8 per 1,000.
- Latinas had the second highest percentage at 13.3% of all births with late or no prenatal care.
- The average charge per day in 2006-2008 for all diagnosis was \$13,039.
- Tuberculosis (TB) rates ranged from 8.4 to 34.4 per 100,000 population. The cities of Garden Grove and Westminster had the highest rate of TB cases in OC.
- Racial and ethnic minorities disproportionately represent the majority of TB cases in OC. Asian Pacific Islanders (61%) and Latinos (29%).
- The top ten leading causes of death in OC were Heart Disease (1), Cancer (2), Stroke (3), Lung Disease (4), Alzheimer's (5), Unintentional Injury (6), Influenza & Pneumonia (7), Diabetes (8), Cirrhosis (9), and Suicide (10).
- Diabetes was among the top five leading causes of death for Latinos and sixth for Asian & Pacific Islanders in OC.
- 44.6% of the nearly 700,000 annual visits to EDs by OC residents could have been avoided or otherwise treated in a primary care setting.

- The highest percentage (48.2% to 51.7%) of avoidable ED visits were made by patients residing in generally less affluent central and northern parts of the county, specifically Santa Ana, west Anaheim, and parts of Buena Park and Stanton.
- The second highest range (44.7% to 48.1%) included much of the areas surrounding Santa Ana such as Orange and parts of Tustin, Placentia, Fullerton, Garden Grove, Westminster and La Habra.

St. Joseph Health, St. Joseph Hospital Orange, anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the St. Joseph Health, St. Joseph Hospital Orange CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by St. Joseph Health, St. Joseph Hospital Orange in the enclosed CB Plan/Implementation Strategy.

Identification and Selection of DUHN Communities

Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes and census tracts where there is a higher prevalence or severity for a particular health concern than the general population within our ministry service area.

DUHN Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Low income underserved and uninsured population living in SJO CBSA.	Culturally appropriate and affordable medical, dental and vision services.	Strong local Coalition of OC Community Clinics provides a safety net for underserved medically vulnerable population.
Low income underserved and uninsured school-age children.	Appropriate and accessible oral health education, screening and treatment.	Engaged community partners with a strong interest to collaborate and address identified dental health crisis.
Clinic diabetic patients referred by providers from La Amistad or Puente clinics.	Culturally appropriate health education, wellness and prevention services with a focus on diabetes.	The population has an understanding of their chronic disease and is relatively motivated to manage their disease.
Low income underserved and uninsured children (0 to 18 years of age).	Assistance with enrollment and retention of available public health insurance programs.	Community partnerships in OC have dramatically strengthened around the area of enrollment and care coordination. Multiple enrollment sites throughout OC.

FY13 Community Benefit Report

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Underinsured mothers with newborns suffering from postpartum depression.	Affordable screening and treatment for postpartum depression.	SJH program is unique in that we provide screening, treatment and education with a Licensed Behavioral Health Clinician.
Low income overweight children in selected OC schools.	School-based childhood obesity prevention and intervention programs.	Local school districts are supportive and willing collaborative partners.
Low income underserved women 35 years or older and men age 55 or older at risk for cardio vascular disease.	Screening, referral and treatment for cardio vascular disease.	Accessible community locations to provide services. Strong support for service delivery by community partners.

PRIORITY COMMUNITY HEALTH NEEDS

Figure 1, below, describes the community health needs identified through the SJH, St. Joseph Hospital Orange CHNA. Those needs that the hospital does not plan to address are noted ².

Figure 1

Health Needs Identified through CHNA	Plan to Address
Health Care Access and Coverage	Yes
Health Care Utilization	No
Health Care Status	Yes
Mental/Behavioral Health	Yes
Chronic Diseases	Yes
Maternal/ Infant Health	Yes
Obesity, Nutrition and Exercise	Yes
Dental Health	Yes
Older Adult Health	No

Needs Beyond the Hospital’s Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continue our Mission through community benefit program and by funding other non-profits through our Care for the Poor Program managed by the St. Joseph Health, St. Joseph Hospital Orange.

Furthermore, St. Joseph Health, St. Joseph Hospital Orange will endorse local non-profit organization partners to apply for funding through the [St. Joseph Health, Community Partnership Fund](#). Organizations that receive funding provide specific services, resources to meet the identified needs of underserved communities through St. Joseph Health communities.

The following community health needs identified in the ministry CHNA will not be addressed and an explanation is provided below:

Health Care Utilization: St. Joseph Hospital is no longer involved with the MediKids Initiative whose primary focus was to enroll low-income children in appropriate health insurance programs and ensure their utilization of services. Consequently, once the MediKids Initiative ended, the hospital was instrumental in the development of the Children’s Health Initiative of Orange County (CHIOC). The hospital collaborates

closely with CHIOC to ensure that they track access and utilization rates for all families enrolled in appropriate and affordable health insurance.

Maternal/Infant Health: St. Joseph Hospital focuses its efforts around outpatient maternal/infant health services for the underserved community in the area of postpartum depression services and our Bridges for Newborns Program. Bridges provides psycho-social needs assessments and referrals to community resources for new mothers and their infants. Maternal/ Infant Health Services for the broader community include a larger scope of services. Those programs include, ongoing Lactation Services, Mother/Baby Assessment Center, Maternal/Fetal Health Program, Parent Education/Support Groups and Child Safety classes. The hospital has a long standing collaborative relationship with a local non-profit organization that specifically focuses on maternal/infant health, MOMS of Orange County. The hospital has partnered on a number of collaborative with MOMS to further their mission and vision of serving underserved low income pregnant women have positive health outcomes for themselves and their newborns.

Older Adult Health: St. Joseph Hospital does not have Older Adult Health Programs targeting the underserved population. However, the hospital will provide referrals to local community-based organizations serving the underserved older adult population.

In addition, St. Joseph Health, St. Joseph Hospital Orange will endorse local non-profit organizations/partners to apply for funding through our St. Joseph Health Foundation. Organizations that receive funding provide specific services, resources and meet the needs of the underserved communities that St. Joseph Hospital is unable to serve due to limited resources or lack of expertise in those areas of health.

² A number of community health needs are already addressed by other organizations and will not be addressed in the implementation plan report.

ST. JOSEPH HEALTH, ST. JOSEPH HOSPITAL ORANGE FY12 – FY14 Community Benefit Plan/Implementation Strategies FY13 Accomplishments

Initiative: *Access to Primary Care*

Description: The principal intent of programs addressing Access to Primary Care is to improve community health. Such programs will focus on creating or increasing availability and accessibility to medical and vision care. Such programs may include but not be limited to primary medical care (at a fixed or mobile clinic) and vision mobile services.

Key Community Partners: Corbin FRC, Santa Ana; Friendly Center, Orange; St. Ann's Catholic Church, Santa Ana; Delhi FRC, Santa Ana; Lestonnac Free Clinic, Orange; American Diabetes Association; Braille Institute; OC Health Care Agency, Santa Ana; St. Jude Neighborhood Health Center, Fullerton; Latino Health Access, Santa Ana; Children's Health Initiative of Orange County.

Goal (Anticipated Impact²): Expand access to primary care to residents at or below 200% FPL in the SJO Community Benefit Service Area.

Target Population (Scope): Disproportionate Unmet Health Need (DUHN) population (low-income adults and children) living in the hospital's Community Benefit Service Area.

How will we measure success? Outcome Measure (Evaluation Plan³):

The total number of unduplicated patients served (medical and vision).

Three-Year Target: Increase total number by 5%.

Strategy 1: Partner with community sites in Santa Ana and Anaheim where mobile medical and vision services can be provided.

² **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

³ **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

Strategy Measure 1: Number of site partnerships as established by Memorandum of Understanding.

Strategy 2: Provide Medical Services for adults.

Strategy Measure 2: Number of patient encounters in Medical Services.

Strategy 3: Provide Vision screening, treatment for eye disease and injury, and optical supplies including corrective lenses and frames.

Strategy Measure 3: Number of optometry visits for eye disease, injury and refractive error.

Strategy 4: Provide individualized education about treatment plan for vision and eye care at patient visits.

Strategy Measure 4: % of participants who adhere to treatment plans.

Strategy 5: Provide enrollment assistance and care coordination for low-income children in appropriate health insurance programs.

Strategy Measure 5: Number of low-income children enrolled in appropriate health insurance programs.

FY13 Accomplishments:

The goal of increasing access to the underserved population was achieved through La Amistad Medical services and Puente Vision services. Initially, this goal included Puente Medical Mobile Services. However, due to lack of funding, Puente Medical Mobile Services ceased providing care in FY 13. The number of unduplicated patients served by La Amistad Medical and Puente Vision services totaled 4,190. This was a slight increase from FY 12 (4,158) taking into account the loss of Puente Medical Services. A total of 419 patients received low-cost prescription frames (cost per frame is \$6 - \$16). Puente Medical and Vision mobile services engaged 5 new community partners to provide access to care to the underserved in their communities. Adult patients receiving medical and vision visits totaled 13,109. On average, 21% of diabetic patients completed their annual eye exam. The number of low-income children enrolled in appropriate health insurance programs totaled 1,899.

Initiative: *Access to Dental Care*

Description: Oral health is closely linked to the overall health of an individual. Access to Dental Care Programs will address preventive and restorative dental needs of the community. Services will be provided via a fixed site clinic and mobile site locations.

Key Community Partners: Crittenton Family Services, Fullerton; Northgate Gonzalez Supermarket, Anaheim; Valley High School, Santa Ana; Parkview Elementary School, Garden Grove; Oakview Preschool, Huntington Beach; Ponderosa FRC and School, Anaheim and Garden Grove city line; Garfield Elementary School, Santa Ana; Santa Ana Police Officers Association, Santa Ana; and Corbin FRC, Santa Ana; Healthy Smiles of Orange County.

Goal (Anticipated Impact⁴): Reduce dental decay prevalence among low-income residents in SJO Community Services Area.

Target Population (Scope): Disproportionate Unmet Health Need (DUHN) population living in the hospital's Community Benefit Service Area.

How will we measure success? Outcome Measure (Evaluation Plan⁵): % of children and adults with dental caries (cavities).

Three-Year Target: Decrease to 34.8% of dental caries to meet National/State and Local benchmarks.

Strategy 1: Provide preventive dental treatment to children.

Strategy Measure 1: # of preventive dental treatment provided to children.

Strategy 2: Provide restorative dental treatment to children

Strategy Measure 2: # of restorative dental treatment provided to children.

Strategy 3: Ensure complete dental treatment for children.

Strategy Measure 3: % of dental treatments completed for children.

Strategy 4: Provide restorative dental treatment for adults.

⁴ **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

⁵ **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

Strategy Measure 4: # of restorative dental treatment provided for adults.

Strategy 5: Collaborate with new community partners focused on children's oral health.

Strategy Measure 5: Number of new collaborative.

FY13 Accomplishments:

The percentage of children and adults with caries was 36% by year end compared to 43% at baseline. The average number of preventive dental treatment encounters provided to children and adults was 1.1 visits per year compared to baseline at 1.3 visits per year. The average number of restorative dental treatment encounters provided to children and adults was 1.1 visits per year compared to baseline at 1.5 visits per year. The percentage of dental treatment completion for children by year end was 44% compared to 43% at baseline. Puente Dental mobile services engaged 7 new collaborative partners to provide access to care to the underserved in their communities.

Initiative: Wellness, Prevention and Intervention

Description: Healthy Communities have access to programs and services that address the overall wellbeing of individuals as well as the community as a whole. Programs addressing Wellness, Prevention and Intervention will target health conditions, and lifestyles that contribute to health disparities in the underserved communities. Their emphasis will be on early identification of health risks and providing interventions that are culturally appropriate and yield quantifiable health benefits.

Key Community Partners: Local Unified School Districts in OC; Family Resource Centers in OC; SJO Heart and Vascular Center and Puente a la Salud Mobiel Clinics; The Cambodian Family, Jamboree Housing, and Alta Med to provide technical and advisory support for the Office of Minority Health Partnerships Active in Communities (PAC) to Achieve Health Equity Grant.

Goal (Anticipated Impact⁶): Improve health of residents living in the SJO Community Benefit Service Area by reducing their risk of negative health outcomes.

Target Population (Scope): Disproportionate Unmet Health Need (DUHN) population (adults and children) living in the hospital's Community Benefit Service Area.

⁶ **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

How will we measure success? Outcome Measure (Evaluation Plan⁷): Percent of persons defined as at risk of negative health outcomes.

Three-Year Target: Decrease persons at risk by 33%.

Strategy 1: Reduce childhood obesity by promoting a healthier lifestyle.

Strategy Measure 1: # of children who maintain or decrease their Body Mass Index (BMI).

Strategy 2: Use clinical measures to determine health improvement associated with behavioral changes for diabetic population.

Strategy Measure 2: # of patients diagnosed with diabetes that decrease their Hemoglobin A1C by at least one percent point from baseline.

Strategy 3: Educate population diagnosed with diabetes on the value of encouraging family members to eat better and exercise more.

Strategy Measure 3: # of patients diagnosed with diabetes who report that information received in program resulted in a positive health behavior change within their family.

Strategy 4: Provide access to cardiovascular education, screening and treatment.

Strategy Measure 4: Number of cardiovascular screenings and treatment referrals to appropriate clinic partners.

Strategy 5: Collaborate with new community partners focused on chronic disease risk reduction.

Strategy Measure 5: Number of new collaborations with key community partners.

FY13 Accomplishments:

The percentage of persons defined as at risk for negative health outcomes was 41% compared to 45% at baseline. The 4% decrease of at risk persons is due to multiple efforts to identify persons at risk. For instance, the Cardiovascular Screening Program increased the number of community sites where they provided care increasing the number of persons identified at risk. Forty-one (41%) of cardiovascular screening participants were screened and referred for treatment to appropriate clinic partners. Seventeen percent (17.4%) of SJO students decreased their weight status to a healthier category (56 of 321). For FY 13 the evaluation consultant was not available to analyze

⁷ **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

and interpret data for Strategy Measure 2 and Strategy Measure 3. Community Benefit Programs addressing at risk populations engaged 8 new collaborative partners to provide access to care to the underserved in their communities.

Initiative: *Postpartum Depression Program*

Description: Postpartum depression is an illness, like diabetes or heart disease. According to the National Institutes of Health, it affects 10-15% of women. Many get depressed right after childbirth, but some women don't feel "down" until later. Depression that occurs within six months of childbirth may be postpartum depression. The period of time that this depression lasts can vary. Some women feel better within a few weeks, but others don't feel like themselves for many months. Our Postpartum Depression Program provides screening and treatment on campus to all mothers referred to the program.

Key Community Partners: MOMS of Orange County; local physicians (OBGYNs and Pediatricians); SJO inpatient psychiatry unit; and SJO Mother Baby Assessment Center.

Goal (Anticipated Impact⁸): To reduce postpartum maternal depression.

Target Population (Scope): Mothers who deliver at SJO who are a) screened by Bridges Program using a psycho-social screening tool, and b) are at 10 or above on the Edinburgh scale prior to discharge; or any mothers referred by physicians; and any mothers referred Bridges or other professionals.

How will we measure success? Outcome Measure (Evaluation Plan⁹): The percent of clients who have recovered from Postpartum Depression.

Three-Year Target: 100% of mothers recover.

Strategy 1: Increase # of sessions per client in treatment.

Strategy Measure 1: Average # of session per client in treatment.

Strategy 2: Determine appropriate intervention for women in the program.

Strategy Measure 2: % of improvement/recovery score for women who are taking medication and those who are not taking medication.

⁸ **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

⁹ **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

Strategy 3: Reduce the financial burden to clients.

Strategy Measure 3: Average financial cost to the patient for treatment. Excludes FAP qualifying patients.

FY13 Accomplishments:

100% of mothers who entered treatment for Postpartum Depression recovered compared to 85% at baseline. On average, 5 sessions were provided to mothers who completed treatment. PPD implemented a low cost fee program for individual and group sessions in an effort to reduce the financial burden to clients. 100% of mothers, who required medication during the program, received appropriate medication, used their medication, and recovered from postpartum depression. PPD provided 618 individual and/or group sessions to mothers with postpartum depression.

FY13 Community Benefit Investment

FY13 COMMUNITY BENEFIT INVESTMENT

St. Joseph Hospital Orange

(ending June 30, 2013)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services ¹⁰	Net Benefit
Medical Care Services for Vulnerable ¹¹ Populations	Financial Assistance Program (FAP) (Charity Care-at cost)	\$8,698,922
	Unpaid cost of Medicaid ¹²	\$19,033,317
	Unpaid cost of other means-tested government programs	\$7,423,808
Other benefits for Vulnerable Populations	Community Benefit Operations	\$0
	Community Health Improvements Services	\$822,572
	Cash and in-kind contributions for community benefit	\$33,976
	Community Building	\$0
	Subsidized Health Services	\$6,605,928
Total Community Benefit for the Vulnerable		\$42,618,523
Other benefits for the Broader Community	Community Benefit Operations	\$464,179
	Community Health Improvements Services	\$1,715,960
	Cash and in-kind contributions for community benefit	\$0
	Community Building	\$0
	Subsidized Health Services	\$9,401
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	\$667,570
Total Community Benefit for the Broader Community		\$2,857,110
TOTAL COMMUNITY BENEFIT (excluding Medicare)		\$45,475,633
Medical Care Services for the Broader Community	Unpaid cost to Medicare ¹³ (not included in CB total)	\$29,599,866

¹⁰ Catholic Health Association-USA Community Benefit Content Categories, including Community Building.

¹¹ CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid, Medicare, California Children's Services Program, or county indigent programs. For SJHS, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.

¹² Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.

¹³ Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial¹⁴ Summary of Accomplishments

SJO's Executive and Management Team members lent their expertise, time and talent to outside organizations committed to delivering healthcare excellence and healthy communities.

The following lists all Board membership participation and volunteer work.

- *Chair for the Southern California region of Hospital Association of Southern California*
- *Board of Trustees member for Taller San Jose*
- *Western University Advisory Board member and California State University, Fullerton Advisory Board member*
- *California Hospital Patient Safety Organization Board member*
- *Southern California Association for Healthcare Risk Management Board member*
- *Children's Health Initiative of Orange County Advisory Committee member*
- *El Sol/SOS Wellness Center Advisory Committee*
- *Orange County Coalition of Community Health Centers member*
- *Bethany House Board member*
- *Casa Teresa Board member*
- *CNI Career Network Institute Advisory Board member*
- *California State University, Fullerton Nursing Advisory Board member*
- *MOMS of Orange County Board member*
- *Sigma Theta Tau Nursing Honor Society Board member*
- *Leadership Orange Executive Committee member*
- *Chairman of Health Associates Federal Credit Union Board member*
- *National Philanthropy Day Committee*
- *Association of Fundraising Professionals, Orange County Board member*
- *National Renal Administrators Association Board member*
- *National Kidney Foundation Public Policy Committee*
- *Association for the Advancement of Medical Instrumentation- Board member Water Treatment and Dialysis Equipment*
- *Kidney Care Partners Advocacy Committee*
- *Orange County of the Association for Clinical Laboratory Management*
- *Pet Therapy Program volunteer*
- *No One Dies Alone Program volunteer*
- *Volunteer Advisory Board member*
- *Mock interviewer volunteer for Taller San Jose*
- *National Kidney Foundation Council of Nephrology Nurses & Technicians Executive Committee Board member*
- *Renal Disease and Detoxification Committee*
- *Home Care Applications Committee*
- *Fistula First Breakthrough Initiative*
- *County of Orange Health Care Agency Dialysis Advisor*

¹⁴ Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.

FY13 Community Benefit Report

- *Focus Orange County volunteer*
- *Endoscopy and Surgery Center staff volunteer for Access OC (free surgeries for the uninsured)*
- *Association of Fundraising Professionals Orange County Board member*
- *Advisory Council, State of California, Breast and Cervical Cancer Chair*
- *American Liver Foundation Greater LA and Orange County Medical Advisory Board*
- *Physician Engagement Team Member, American Cancer Society, California Division*